Wish Referral

About the child

Child's full name

Male/Female | Child's date of birth

Qualifying illness

Primary language spoken

Has the child received or registered for a wish from another organisation? Yes ☐ No ☐ Don't know ☐

If Yes, which organisation?

About the family

Parent/guardian name

Home address

Postcode | Home telephone number

Mobile number: Mother | Father

Email address

About the referrer

Name

Your relationship to the child

Your full address (if different from above)

Postcode | Telephone number

Mobile number | Email address

Where did you hear about Make-A-Wish?

About the child's Consultant/Doctor (NOT your GP)

Name of Consultant/Doctor

Name and address of hospital

Consultant/Doctor's telephone number

Consultant/Doctor's fax number

Email address

Medical release form

Please fill in the section below, giving Make-A-Wish permission to receive medical information about this child.

If the child is over 16, and they are able, they must sign this part themselves.

I, parent/guardian, **[insert your name]**

hereby give permission for Consultant/Doctor **[insert your Consultant/Doctor's name below]**

to release the required medical information regarding **[insert child's name below]**

Signed